Patient Name: _____

Birth Date:_____

Today's _____ Date:

Advanced Cosmetic and Implant Dentistry of Maryland

Medical Information

Personal **Physician**: _____

Name Address Phone #

Yes **No**

☐ ☐ 1. Have you been hospitalized within the past two years? For what?

_____

_____

2. Are you currently being treated by a physician? For what? _____

_____

☐ ☐

☐ ☐ 3. Are you currently taking any medications or drugs? What?

Drug Name	**Amount**	**Purpose**
(if more please continue on another page)		

☐ ☐ 4. Have you ever received counseling for excessive alcohol and/or prescription drug use?

☐ ☐ 5. Are you allergic to any drugs? What? _____

☐ ☐ 6. Are you allergic to any metals? What? _____

☐ ☐ 7. Any other allergies? What? _____

☐ ☐ 8. Do you bleed excessively upon injury? _____

☐ ☐ 9. Are you or Could You Be Pregnant? Or are you breastfeeding? _____

☐ ☐ 10. Have you ever been pre-medicated prior to dental treatment? _____

☐ ☐ 11. Do you smoke currently? Approximately how many per day? _____

☐ ☐ 12. Have you smoked routinely in the past? Years: _____

Person to be Contacted in an Emergency (Required):

_____

Name Phone#

Circle any of the following conditions which you have had

a. Need for "blood thinners"
b. Asthma (if still relevant)
c. Cancer
d. Diabetes
e. Epilepsy
f. Bisphosphonate treatment or medications
g. Heart Murmur
h. Heart Problem
i. Hepatitis
j. High Blood Pressure
k. HIV
l. Prosthetic Joints
m. Kidney Problems
n. Low Blood Pressure
o. Nervous Breakdown or Psychiatric Therapy
p. Rheumatic Fever
q. Sexually Transmitted Disease
r. Stroke
s. Tuberculosis
t. Other Diseases

If you circled either "h" or "t", please describe condition:

_____
_____
_____
_____
_____

Responsibility and Consent Statement

I give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his staff for diagnostic purposes or dental treatment. I also consent to having records taken, which may include study models, photographs, and x-rays. I have the right to decline any treatment before proceeding.

Signature _____ **Date** _____
Patient (or Guardian)

Signature _____ **Date** _____
Attending Dentist